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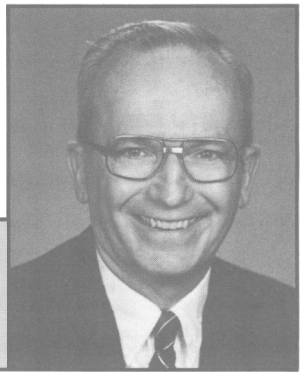

From Our President

Neil O. Ward, M.D.

Can We Mend The Medicare Mess?

Over twenty percent of ArMA's active members responded to our inquiries about their experience with new Medicare rules and regulations. Only one percent said new rules had a positive effect on patient care. Thirty-four percent indicated no effect on their practices with the following generic explanations appended to several of the survey responses: (a) "No effect because I don't treat Medicare patients" or (b) "No effect because my office absorbed the cost of care denied or undercompensated." Fully *sixty-five percent* of ArMA respondents said the new Medicare rules and regulations *adversely affected* the quantity and/or quality of their patient care!

When asked for actual numbers, the responding physicians estimated 15,000 Arizona patients have been adversely affected by new Medicare rules. This can be extrapolated to cover the entire active physician population of the state to *conservatively* estimate that more than 100,000 Medicare patients have been denied the best care available because of Federal incentives to limit medical services!

Medicare programs have assured the elderly and the disabled high quality, mainstream, medical care. The nation's budget deficits have made Medicare a prime target for cost containment. Short term cost containment "solutions" including the 1973 physician fee freeze and the hospital DRGs have not reduced Medicare cost. Nor are they likely to do so with an aging population, better and more expensive technology to treat senior citizens who consume four times the health care resources of those under age 65, and a DRG system that motivates "quicker and sicker" discharges of the elderly into the community.

This is a complex problem that can be solved cooperatively by informed physicians, patients and our political representatives.

1.) Physicians must constrain colleagues who would provide unnecessary medical services. This can be accomplished through educational, ethical, economic and due process peer review incentives. We currently don't know the "right rate" of medical care. Arizona physicians must study the growing mountain of computerized data available to hospitals, the PRO, the Department of Health Services and third-party payors. We plan to do that at ArMA through ArMAP (Arizona Medical Assessment Programs).

The percentage of physicians accepting Medicare assignment can increase even while "participation" in Medicare declines. The AMA

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Use of Automatic External Defibrillators

Use of automatic external defibrillators (AEDs) by emergency medical personnel may facilitate treatment for more victims of heart attacks, according to a study reported recently in *JAMA*. The study found that automatic devices required less training for proper use and that they delivered shock to the heart one minute faster than standard defibrillators.

Richard O. Cummins, M.D., M.P.H., M.S.C., of the University of Washington, Seattle, and colleagues, compared the effectiveness of both kinds of defibrillators used by emergency medical technicians (EMTs) in treating 321 patients with cardiac arrest. In their study, 116 patients were treated with AEDs, and 158 were treated with standard defibrillators (an additional 47 were treated by EMTs using the standard defibrillator even though they were assigned to use the AED).

Hospital admission and discharge rates of patients were comparable regardless of the type of device used. "The only significant difference observed was in the time from power on to first shock: 1.1 minutes average AUTO group and 2.0 minutes average standard group," the researchers say.

"Automatic external defibrillators appear to have advantages over standard defibrillators in training, skill retention, and faster operation," the report adds, noting that AEDs can make early defibrillation available for a much larger portion of the population.

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Editor's Message

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to the chart on behalf of the patient, but our actual expenditure of time with the patient is not great, and the amount of "caring" that we do is small.

Watching many attendings berate nurses (I've been guilty of this myself) leads me to suggest that we really are off base. We need to be sure that the nursing staff at every hospital is carefully selected and given responsibilities commensurate with their abilities. Furthermore, we should have compassion and understanding for the difficult task they must undertake on a daily basis caring for our sick patients. I believe we have lost sight of the role that the nurse plays in the overall scheme of things and they should be given a greater attention and reward for their efforts. If it were not for the nursing staff at every hospital, our patients would not get the care we are prescribing. It wouldn't hurt to say, "Thank you, for caring for my patient," when you see a good job being done by the nursing staff. They need our support and we need theirs. ■

Marshall B. Block, M.D., Editor

President's Message

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and ArMA urge physicians to consider each patient's financial needs when setting charges and to accept Medicare assignment, reduce fees, or charge no fee at all in cases of true financial hardship.

Physician reimbursement must be more predictable and less inequitable. It is past time we had a resource-based relative value scale based on actual costs including factors such as the time required to provide a service, the complexity of the service, the training, equipment and overhead expense required to provide the service and the risk involved. Congress is working "at" it.

2.) Patients must be aware of cost and co-pay more when appropriate. When the Medicare system is threatened financially, there is no justification for subsidized care to those who are well-to-do. A "means test" may not be popular but it's good for the system. Medical research for better treatment in the near future and the education of new physicians are at risk in the current system that fails to realistically reimburse for medically indicated care.

Patients must be reminded that in our pluralistic society they will not be well-served by being forced into a particular delivery system based on the federal government's administrative convenience or perceived cost savings.

3.) The government must be persuaded to stop rearranging the deck chairs and do what's necessary to save sinking Medicare with sound fiscal policy (see AMA: *Proposal for Financing Health Care of the Elderly,* Report of the Board of Trustees to the House of Delegates Annual Meeting, Chicago, Illinois, June 1986.) It is long overdue!

Remember, *we* are the government and your patients are voters, too. Lobby them. If, as a physician, you perceive politics to be beneath you — reconsider Rudolf Virchow's observation that "medicine is in essence a social science and politics is nothing more than medicine on a larger scale."

Expand your practice a little! ■

Neil O. Ward, M.D., President